TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROPLEX SURGICARE PARTNERS

Respondent Name
TRAVELERS CASUALTY INS CO OF AMERICA

MFDR Tracking Number
M4-17-0006-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
SEPTEMBER 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we have received a payment from the carrier in the amount for $1,189.92 but this is not the amount we are disputing."

Amount in Dispute: $3,073.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement is being issued in accordance with the appropriate Division-adopted fee schedule."

Response Submitted By: William E. Weldon/Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2016	Ambulatory Surgical Care for CPT Code 29876-RT	$3,073.40	$1,883.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29-The time limit for filing has expired.

- 937-Service(s) are denied based on HB 7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
- 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
- W3-Additional payment made on appeal/reconsideration.
- 863-Reimbursement is based on the applicable reimbursement fee schedule.

Issues

Is the requestor entitled to additional reimbursement for ambulatory surgical care center services rendered on February 16, 2016?

Findings

According to the explanation of benefits, the respondent initially denied payment for the disputed services based upon timely filing and a lack of documentation. Upon reconsideration these denials were not maintained and payment of $1,189.92 was issued. The requestor contends that additional reimbursement is due because the payment was not in accordance with the fee guideline. The issue in dispute is whether the requestor is due additional reimbursement per the fee guideline.

The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

28 Texas Administrative Code §134.402(d) states,

> For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

CPT code 29876 is defined as "Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)."

28 Texas Administrative Code §134.402(f)(1)(A) states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
> (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent .

According to Addendum AA, CPT code 29876 is a non-device intensive procedure. The requestor appended modifier "RT-Right Side" to code 29876.

The Medicare ASC reimbursement rate for code 29876 CY 2016 is $1,339.58.

The City wage index for Bedford, Texas is 0.9526.

To determine the geographically adjusted Medicare ASC reimbursement for code 29876, use the following formula:

The Medicare ASC reimbursement rate of $1,339.58 is divided by 2 = $669.79.

This number multiplied by the City Wage Index $669.79 X 0.9526 = $638.04.

Add these two together $669.79 + $638.04 = $1,307.83.

The geographically adjusted Medicare ASC reimbursement rate for code 29876 is $1,307.83.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%

$1,307.83 X 235% = $3,073.40. The respondent paid $1,189.92. The difference between amount paid and MAR is $1,883.48. The division finds the requestor is due additional reimbursement of $1,883.48.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,883.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,883.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

.

Authorized Signature

		3/9/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.